



Original Research Article

## Nursing Student's Experience on Truthful Disclosure of Information to Cancer Patients

Hanaa Hashem<sup>1</sup>, Lamia Ismail<sup>2</sup>

<sup>1</sup>Assistant Professor (Medical Surgical Nursing); <sup>2</sup>Lecturer (Medical Surgical Nursing),  
Faculty of Nursing, Cairo University, Egypt.

Corresponding Author: Hanaa Hashem

Received: 17/11/2014

Revised: 22/12/2014

Accepted: 06/05/2015

### ABSTRACT

**Background:** Disclosure of information to cancer patients is an area that medical professionals often find difficult. In some cases there has been conflict with whether medical professionals should inform their patients or not. Recognizing the information needs throughout the illness and manner of disclosure are pivotal in providing responsive and high-quality care. Therefore, the aim of this study was to explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients.

**Methods:** Eight senior nursing students were selected purposefully to participate in a qualitative, descriptive and contextual study. Data were collected by mean of individual interviews. Data analyzed using the Tesch descriptive analysis method.

**Results:** Nursing students thought that the truth should be delivered gradually during stages of therapy based on patient's psychological state. All of the nursing students consider truth telling as a patient right to take the total control of decision making process for their treatment. Majority of students see the nurses or close family members as a person responsible to break the diagnostic disclosure.

**Conclusions:** Many nursing students found these interactions stressful. In the absence of much effective training nursing students may adopt inappropriate ways of delivering bad news and coping with the emotional fall-out. Recognition of these difficulties has led to many initiatives.

**Key words:** Nursing students' experience, truthful disclosure, cancer patients, qualitative research

### INTRODUCTION

Cancer is a complicated illness, which for many years and in many cultures was perceived as incurable. Cancer meant death, and there was a tendency to hide the diagnosis from the patient. <sup>(1,2)</sup> Prior to the early 1980s, the practice of concealing the diagnosis of cancer and its prognosis was prevalent in medicine as physicians deemed it unethical to reveal what they considered a

"death sentence" and patients were also reluctant to know their true condition. <sup>(3)</sup> Currently health professionals generally prefer to inform cancer patients about their illness. In addition, globalisation of information through the media and internet makes withholding the information from patients very difficult. <sup>(4-7)</sup>

The practice of medicine is refocusing from the traditional paternalistic

model, in which patient involvement is limited to giving or refusing consent to treatment, to a partnership approach, in which the process of shared decision-making requires full information on all the possible outcomes associated with each treatment option. <sup>(8-10)</sup> Similar paternalistic practices are observed in Arab and Islamic cultures. In a survey in Turkey a significant proportion of cancer patients (44%) did not know their diagnosis. In Lebanon, where legislation allows non-disclosure, nearly half of physicians would usually tell the patient about cancer. The great majority of physicians (79%) in Kuwait would withhold the truth if the patient's family requested them to do so, and in Saudi Arabia 75% of physicians preferred to discuss information with close relatives rather than patients themselves, even when the latter were mentally competent. <sup>(11)</sup>

Not disclosing the truth to patients about their diagnosis and prognosis can to some extent be justified in underdeveloped countries; where the quality of health care provided is often poor and lacking in palliative care facilities, patients with terminal cancer face the prospect of dying in discomfort and pain. In countries with more-advanced health systems, patients with terminal cancer can be reassured that everything possible will be done for them and will die eventually with dignity and without pain. <sup>(4,5)</sup>

Medical advances enable early cancer detection and a wider variety of treatment choices; thus disclosure of cancer diagnosis is no longer perceived as a death sentence. Surveys have shown a steady increase for preferred disclosure of cancer diagnosis, and a recent survey revealed that 80.7% of the general public preferred to be told of their cancer diagnosis. In contrast to the increase in the diagnostic disclosure rate, the disclosure of prognosis involving information about patients' survival remains

low; may be due to doctors' reluctance to take responsibility for the potential risks, such as shock and depression. But, this does not mean that doctors believe that patients should be kept ignorant. <sup>(6,12)</sup>

The main purpose of information disclosure is to provide a basis for action and to reduce uncertainty. Uncertainty, doubt or misinterpretation does not offer a foundation for proper psychological and medical support. <sup>(3)</sup> Another purpose of information giving is to enable patients to make informed choices about their own health care and plan for future; engage patients in their care; secure their collaboration and lead to patients' adherence to the therapeutic schemes. <sup>(9)</sup>

On the other hand, when disclosing the truth, there is always the risk of shattering a patient's hopes and dreams. Hope seems to be an essential mechanism for coping with cancer and it can be jeopardized by excessive knowledge and detail. Revealing the stark reality of a cancer diagnosis is often perceived as the passing of a death sentence by the members of the health care team and this may also be the case for patients and their relatives. One of the most common concerns of health care professionals is whether they are justified if harm results from telling the truth. <sup>(8)</sup>

Breaking bad news is not a common practice for nurses, with the exception of nurses in the United Kingdom (UK). Many nurses believe that their role in communicating with patients is secondary to the physician's role. This is probably an easy way of disclaiming responsibility for a task that clearly no health professional wishes to do. <sup>(3)</sup> So, the aim of this study was to explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients.

**Significance of the study:** Cancer is a major health threat with respect to morbidity

and mortality rate in the world. Worldwide, every year cancer rates increase by 2%, 10 million people are diagnosed with cancer and nearly 6 million people are died. Despite remarkable advances in cancer treatment, it remains the most terrifying disease among critical diseases. Most people describe it as; death, pain or disorder. <sup>(13)</sup> However, one of the most difficult issues facing healthcare professionals is telling cancer patients about their diagnosis and prognosis. Disclosure to cancer patient is important in helping them to adjust, participate in decision-making in their treatment option, and to access and receive appropriate support.

Despite general agreement about the benefits of open communication between professionals and patients, there is still strong reluctance against disclosure of cancer diagnosis and prognosis in many cultures, particularly in Asian, Middle-Eastern and Mediterranean regions. <sup>(12,14)</sup> If bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment. A successful relationship between patients and health care providers depends on the establishment of trust, which is strongly connected with truthful communication. <sup>(8,15)</sup>

The importance of nurses' proactive role in disclosure needs to be emphasized to support caregivers in the disclosure process. One of the aims of this study hoped that the result of the study will provide nurses with a base line data to be utilized as a guide in how to do the task more effectively to produce benefits for them as well as their patients. It is also hoped that this research will pave the way for future research collaboration between nurses and other health providers for better informational disclosure.

**Definition of Concepts:** It is important to clarify key concepts used in this study such as:

**Disclosure:** Disclosure is the act of disclosing, uncovering or revealing; bringing to light; exposure (Webster Dictionary, online). <sup>(16)</sup> For this study, the term will be considered as the act of disclosing to cancer patients status, and will entail full disclosure with the patient knowing not only that they are just sick but also the actual name of the disease. Senior nursing students: Senior nursing student's is defined as those who had clinical exposure with cancer patient during their study of medical-surgical; oncology and / or critical care nursing.

**Aim:** To explore nursing student's experience and view on truthful disclosure of information about diagnosis and prognosis to cancer patients.

## **MATERIALS AND METHODS**

**Design:** A qualitative, phenomenological design was used to capture nursing student's experience on truthful disclosure of information about diagnosis and prognosis to cancer patients. The qualitative approach was chosen in order to explore the depth and complexity inherent in disclosure of information as a phenomenon because it allows the exploration of previously unforeseen lines of inquiry. <sup>(17,18)</sup> Also, qualitative research, using a systematic and rigorous inductive approach, explores nursing student's experience, why certain attitudes, beliefs or customs developed or adopted. As such, qualitative inquiry provides a rich interpretation of nursing student's perspectives, experiences and roles. <sup>(19,20)</sup>

**Setting:** The study was conducted in Faculty of Nursing, Cairo University.

**Informants:** Eight senior male and female nursing students were adopted purposefully to participate in the study. Purposeful sampling for qualitative research as a way to reveal the most information about the phenomenon under study. <sup>(21)</sup> Therefore,

criteria for inclusion in this study would be: Undergraduate senior nursing students who passed all courses involving clinical training with cancer patients through Medical-Surgical, Oncology and / or Critical Care Nursing; Students who had previous experiences of cancer nursing patients; and Students who express their willingness to participate and give permission for the interview to be recorded on audiotape will be eligible to participate.

**Tools and Pilot Study:** Unstructured interview was used as a method of data collection. The researcher developed 13 research questions that were used as the foundation to develop the interview questions. A panel of experts was asked to review the research questions and the open-ended interview questions to provide feedback. The interview tool was revised based on the experts' recommendations. With expert's approval, two pilot interviews were conducted before conducting this study. From the data provided by the pilot interviews, the interview tool was finally revised.

The research questions were: "What are your views regarding disclosure of patients' information regarding cancer?" followed by probing questions that sought clarification of participants' initial response such as: "Tell me about your experience of disclosure involving cancer patients"; "Tell me about your feeling, at that time being present during disclosure of information regarding diagnosis and prognosis and explain why?" – "Explain your views on disclosure and justify your view."...etc.

These questions were formulated in the interview guide, which was generated from the issues identified in the investigators' clinical practice, an extensive literature review, and in consultation with both methodological and clinical experts. Also, during the progress of the interviews, the informants requested further explanation

for the questions which was dealt with by the interviewers.

**Procedure:** Once permission was granted, the nursing students who met the criteria for inclusion was recruited. Personal data were collected through individual interviews. An audio tape was used to record the interviews. Two researchers collected the data, with one researcher serving as the interviewer while the other acted as a moderator, taking field notes and operating the audio tape recorder. To maintain confidentiality, identifiers in the form of dates and numbers were used to label the audio tapes. The transcripts from the audio tapes were anonymous. Interview times ranged from 45 minutes to 1.30 hours. The interviews ceased when data saturation or redundancy of responses was determined, that is, when information was repeated without any new views being presented. After each interview, the recordings were transcribed. The researchers read and re-read the data and constructed a coding frame, and then examined themes, across the whole data set, and in the context of each individual's interview.

**Statistical Analysis:** The informants' narratives were analyzed using qualitative methodology; according to the steps outlined by Tesch. They were transcribed verbatim from the audio tapes. The audio tape transcripts were read and re-read by the researchers to make sense of the whole. Data reduction was used in the data analysis process. The researchers identified essential features and patterns of the data, such as extracts from the interviews that represented extracts of the same nature. The data were clustered together into similar topic themes and then organized into categories. The field notes written during the data collection were used to gain the necessary background information. The content of each category was summarized in order to draw conclusions. Literature was used to support the findings. The two researchers then coded

the transcripts independently. This was followed by recoding, after which discussions were undertaken by the two researchers until consensus was reached about the themes and categories. After that, the researchers conducted an independent quality check and verified the findings.

**Ethical consideration:** Permission to conduct the study was requested and obtained from the authoritative committee personal. Nursing Students who voluntarily agreed to be involved in the study; following a thorough explanation of the purpose of the study. Informed written consent was obtained from the participants to be interviewed and make audio recordings. Also, nursing students were assured that they could withdraw from the study at any time, without penalty, if they so wished. Only the research team knew the names of the individual informants. The informants were allowed to ask questions. They were explained to them that the study would be significant in reinforcing the importance of disclosure of information in patient care. It was also explained that the study findings would be disseminated in the form of presentations at conferences and publication in an accredited journal.

## RESULTS

The presentation of data will proceed in two subsections as follows: (I) Nursing students disclosure experience; (II) Three main themes emerged from analysis of the data.

**(I) Nursing students disclosure experience:** The eight senior nursing students who volunteered to participate in the study, three were female and five were male and their ages ranged from 20 – 22 and mean age was 21.63. All the informants were single. The entire informants were in the final year of study except for three, who were in third year. They had already attended the clinical training in the area of

medical-surgical, oncology as well as critical care nursing. Nursing students disclosure experience which include:

**(a) Informants' perspective of the word cancer:** All informants considered that the word "cancer" often accompanies feelings like fear of death, loss of hope, anxiety, shock and suffering. Three from eight informants oppose the use of term "Cancer", and believed this term should not be used directly and should be replaced with a word with much less negative impression like tumor, in an attempt to not be specific. In spite of, all informants were in favor of informing and providing full information to the newly diagnosed cancer patient about the diagnosis, they believed that it is the patient's right to know and the truth should be known to patient gradually.

**(b) As regarding to Cancer diagnosis disclosure experience:** All informants were considered as shock, anxiety, fear of a negative impact on the patient and from patient's reaction.

**(c) Who the best person to tell about cancer diagnosis:** Four informants considered that communicating new medical diagnoses and their prognosis is traditionally a physician's responsibility, and only 3 informants considered that the nurses were the best person to tell about cancer diagnosis. Only one informant considered it as health team responsibility from doctors and nurses should be concerned with such issue.

**(d) From own point of view of informants regarding "Who is in the best position to receive information about the patient's diagnosis and prognosis at first":** All informants indicated that patient's family or head of the family to be present to support the patients during disclosure of information.

**(e) In relation to "Component of disclosure information about cancer"** were nature of disease; risk factors related to disease; signs,

symptoms and diagnosis method; treatment options, its complications, and how to deal with complications; Self care and rehabilitation after recovery; and Prognosis of disease.

**(f) The guiding principles of truth disclosure** that health care professional should apply in this situation from informants own point of view were: create a comfortable setting in proper time and place, manage interruptions; trust relationship between patient, family and health care team; ensure privacy; involve significant others, such as family / caregiver in discussion; presence of good role model, build therapeutic relationship, communicate well with patient's family (good listening, eye contact, proper body language); health care provider who disclose information must be knowledgeable about disease; and responding to the patient's emotions with empathic responses.

**(II) Three main themes emerged from analysis of the data were:**

***Factors influencing the disclosure of information:*** All informants listed their views about five main important factors in priority which health care professionals should take into consideration when deciding whether or not to disclose a cancer diagnosis: strength of Self-religiosity; good role model about cancer; presence of psychological support / family support system, level of education; and the patient had readiness to listen and accept the diagnosis. All informants thought that all this factors must be considered to avoid negative consequence of disclosure of information.

***Opportunities that may facilitate truthful disclosure of information:*** All informants were ranking the motivating factors to disclose the information as: strength of Self-religiosity; educational level and health literacy; good psychological status of patient; presence of family support system;

and expectation of patients and prior illness experience. So, from informants own point of view in priority; the benefits of disclosure were: adherence to management regimen; cooperation of patient during execution of treatment plan; adherence during follow – up; build good relationship between patient, family and medical team; and sense of hope and adaptation.

***Threats/Challenges that may face truthful disclosure of information:*** The informants ranked the preventing factors to disclose the information as: weak Self-religiosity; absence of family support and poor psychological status as hopelessness from recovery; age of the patient is considered the challenging factor facing information disclosure as younger aged patients is most difficult to be informed; cancer staging, especially terminally stage cancer; and misconception about disease.

So, the informants think about the negative consequences of this disclosure if this factors not considered as: non-adherence to therapeutic regimen such as medication and food; shock, loneliness and hopelessness; fear, anxiety and careless regarding performance of social role as job, education, or any responsibilities; fatalistic thinking / death, finally but rare, suicidal. Moreover, All of the informants revealed that in their whole educational experience, especially in relation to studying of behavioral sciences, there was lack of the clinical application aspects that prepared them to handle difficult clinical patients situation such as truth-telling.

## **DISCUSSION**

The discussion of the research result is presented in two main sections as follows:

**(I) Nursing students disclosure experience:** which include: **(a) Informants perspective of the word cancer and cancer diagnosis disclosure experience:** Disclosure of the cancer diagnosis is a

difficult task; as research informants were exposed to clinical and academic environments through the course of their study, they believed that the word “cancer” often is accompanied by feelings like fear of death, loss of hope, anxiety, shock and suffering. Thus cancer diagnosis disclosure experience to the patient is considered as shock, anxiety provoking, fear of a negative impact on the patient and from patient's reaction. Three from eight informants oppose the use of term “Cancer”, and believed this term should not be used directly and should be replaced with a word with much less negative impression like tumor, in an attempt to not be harmful to patients' feeling. All informants were in favor of informing and providing full information to the newly diagnosed cancer patient about diagnosis, as they considered it as one aspects of patient's right.

Lending support to this speculation, some of studies mentioned that disclosing to a patient that they have cancer is a critical, but sensitive issue. Although there has been great progress in cancer diagnosis and treatment, some still envision the diagnosis of cancer as a sentence of death, also believed that diagnosis should be delivered with vague wording considering the emotional and social status of patient, not using the word cancer and tell to have mass or lump without explaining its nature. (15,22,23)

Nonetheless, telling the patient the truth is not only an ethical issue and a way of building confidence within the doctor - patient relationship, but also a patient's right. (14) Despite general agreement about the benefits of open communication between professionals and patients, there is still strong resistance against disclosure of cancer diagnosis and prognosis in many cultures, particularly in Asian, Middle-Eastern and Mediterranean regions. (5,12)

**(b) Who the best person to tell about cancer diagnosis:** All informants considered that communicating about new medical diagnoses as cancer and their prognosis is traditionally a health care professionals responsibility; four informants were consider it as a physician's responsibility, and only three informants considered that the nurse were the best person to tell about cancer diagnosis. Only one informant considered it as health team responsibility including both doctors and nurses. The same finding revealed that in most cases, a physician is the one that disclosed the diagnosis of cancer. A very small proportion of other health professionals (nurses, social workers and psychologists) disclosed cancer diagnosis (0.5%) or poor prognosis (0.9%). (8,10,24)

Reasons include the health care professionals refrain from truthful disclosure to cancer patients are perceived lack of training, stress, no time to attend to the patient's emotional needs, fear of a negative impact on the patient, uncertainty about prognostication, requests from family members to withhold information and a feeling of inadequacy or hopelessness regarding the unavailability of further curative treatment. (10,24)

**(c) Who is in the best position to receive information about the patient's diagnosis and prognosis at first:** All informants thought that the patient's family or head of the family are in the best position to receive the information about the patient's diagnosis and prognosis, to be prepared to provide support to the patients during disclosure of information about cancer. Some research conclusion revealed that the majority of doctors both in developed and developing countries tell the truth more often today than in the past, but some, especially in developing countries prefer to disclose this diagnosis to the next of kin. (11) These go on the same vein with some studies reported

that in family-orientated countries such as Spain, Italy, Greece, Saudi Arabia, Egypt, Singapore, Japan and China, the family assumes the responsibility of decision-making for the patients and the majority of physicians prefer to disclose the truth on cancer diagnosis and prognosis to the next of kin to protect the patients from unnecessary despair and a feeling of hopelessness by excluding them from the process of information exchange. <sup>(25)</sup>

**(d) Component of disclosure information about cancer:** According the informants points of view, disclosure of accurate information may help to decrease patients' negative experiences and increase their active involvement in treatment plans, so during the treatment phase, all informants suggested that patients with cancer seek information about cancer in terms of its nature; signs and symptoms; risk factors related to disease, treatment options, its complications, and how to manage them; self care and rehabilitation after recovery; and prognosis of disease especially extent of disease spread and chances of cure.

This view point was supported by study findings of research which stated that patient with cancer seek information about cause, diagnosis, treatment plan, potential side effects, prognosis, psychosocial aspects of their illness, and the potential impact of these aspects on their quality of life. They added that an appropriate disclosing technique can give patients a sense of control, increasing their hopefulness. Being able to confide in doctors their fear, they may improve their ability to cope with their suffering, improving patients' psychosocial well-being and coping abilities. <sup>(8,26)</sup>

**(e)** The informants of the current study reported their views about the **guiding principles of truth disclosure** that should be applied with cancer patients according to the following order: create a comfortable setting in proper time and place, manage

interruptions; building a trust relationship, between patient, family and health care team; ensure privacy; involve significant others, as family / caregiver in discussion; presence of good role model; build therapeutic relationship, use proper communication skills with patients and family through good listening, eye contact, proper body language; health care provider who disclose information must be knowledgeable about disease; and responding to the patient's emotions with empathy. This view point of informants go in accordance with a study findings recommended that the task of breaking bad news can be improved by understanding the process involved and approaching it as a stepwise procedure, applying well-established principles of communication and counseling. The six steps of spikes as: setting up the interview; assessing the patients' perception; obtaining the patient's invitation; giving knowledge and information to the patient; addressing the patient's emotions with empathetic responses; and strategy and summary. <sup>(27)</sup>

Some studies concluded that truth telling practice and preferences is a cultural artifact to certain extent. Honest and truthful disclosure is an extremely difficult task. Physicians often find the disclosure of cancer diagnosis to the patient as an embarrassing job. Few healthcare workers have received sufficient training in the "breaking bad news" tactics. <sup>(23)</sup>

**(II) Three main themes emerged from analysis of the data: including:**

***Factors influencing the disclosure of information:***

All informants suggested five main important factors in priority which should be taken into consideration when deciding whether to disclose a cancer diagnosis: strength of Self-religiosity; availability of good role model about cancer; presence of psychological support / family support

system; level of education; and patient's readiness to listen and accept the diagnosis. All informants thought all these factors must be considered to avoid negative consequences of disclosure of information. Some researchers found that how bad, sad, or difficult information is received depends on many factors, including expectations, previous experiences, and general personality disposition. <sup>(28)</sup> Another researcher added that as factors negatively influencing truth telling, 63% considered patient's bad physical state, 63% disease fatality, 50% patient's low cognitive state and 45% family's objections. <sup>(15)</sup>

***Opportunities that may facilitate truthful disclosure of information:***

In current study, all informants were ranking the motivating factors to facilitate the disclosure of information as: strength of Self-religiosity; educational level and health literacy; good psychological status of patient; presence of family support system; and expectation of patients and prior illness experience. The same finding was revealed that high education status positively affected this tendency, possibly due to the fact that being better informed leads to less fear from cancer and perhaps because of greater confidence in developing treatment strategies and more exposure to Western trends and values. Unmarried people were younger and better educated, and this may be the explanation for the positive tendency for them to favor disclosure to the patient. <sup>(2)</sup>

Regarding the assumption that truth-telling is always beneficial to patients; the findings revealed that all informants had listed the benefits of disclosure as: adherence to management regimen; cooperation in treatment modalities; adherence during follow-up; build good relationship between patient, family and medical team; creating a sense of hope and ability for adaptation. Some studies found that the benefits anticipated from disclosure

of information were as follows: patient-professional cooperation (88%), patient's compliance (82%), arrangement of patient's pending personal issues (75%), avoidance of repeated questions (37%), and others such as control of emotions, participation in therapeutic decisions, better coping with treatment problems, change of lifestyle, understanding of symptoms and trust in doctor, at a sum of 14%, while 11% considered truth disclosure as non beneficial. <sup>(3,15)</sup>

In general, the benefits of providing patients with information include increased satisfaction with and participation in the consultation, decreased anxiety, and increased ability to cope. <sup>(16)</sup> Also, effective delivery of bad news can result in patients who are the following: better informed; more motivated to follow through with further evaluation and treatment; less emotionally distressed; better able to ask questions and participate in the clinical encounter; better prepared to make treatment decisions; better able to navigate the health care system; and clear about the level of uncertainty of the diagnosis. <sup>(28)</sup>

***Threats/Challenges that may face truthful disclosure of information:***

The informants ranked threats and challenges that may serve as preventing factors as: weakness of Self-religiosity; absence of family support and poor psychological status resulting from sense of hopelessness of recovery; age of the patient is considered a challenging factor facing information disclosure as younger in age that is most difficult to be informed; cancer staging, especially terminally stage cancer; and misconception about disease. In this regard, some studies mentioned that breaking bad news to cancer patients is inherently aversive, described as "hitting the patient over the head" or "dropping a bomb". <sup>(27)</sup> Also, breaking bad news can be particularly stressful when the clinician is

inexperienced, the patient is young, or there are limited prospects for successful treatment. <sup>(1)</sup>

So, the informants stated their views of the factors to be considered as indicative of the negative consequences of disclosure as: non-adherence to therapeutic regimen as medication and food; shock, loneliness and hopelessness; fear, anxiety and carelessness regarding performance of social role as job, education, or any responsibilities; fatalistic thinking / death; and Finally but rare, suicidal. The same findings revealed that shock, horror, anger, stoic acceptance, disbelief, and denial are all possible reactions and anyone charged with breaking bad news needs to be able to cope with these emotions. <sup>(28)</sup>

Evidence suggests that there are potentially negative consequences for an individual who lacks insight into their disease stage. These include unsatisfactory management of the advanced stage of illness, such as unnecessary (and unwanted) hospital admissions, a higher proportion of hospital deaths and a lack of, or late, referral to palliative care services, poorer symptom control, less end-of-life planning and consequently reduced patient choice. <sup>(9)</sup> In addition, psychological consequences are documented, including increased mistrust and feelings of abandonment in patients. It is important of course, to understand that disclosing such negative news might result in a loss of hope, but still worse is hiding this information, which could have a far more negative impact on the management and adherence of a treatment plan in addition to denying the patient the right of choice, which is considered among the most basic health and human rights. <sup>(29,30)</sup>

## CONCLUSION

The delivery of sad, bad, and difficult news will always be an unpleasant but necessary part of medicine. In the

current study, all informants reported that it is difficult to engage in open communication with the patients, because their academic education did not sufficiently train them in communication skills. These results indicate that although many nursing students believe that the patients should be informed and know their condition, lack of training in communication skills and emotional capabilities is a major obstacle to achieving this. So, Training health-care professionals how to do the task more effectively will produce benefits for them as well as their patients, but this training needs to be based on sound educational principles, informed by evidence, and assessed and monitored adequately. Future training initiatives may need to include more about ethics and team approaches to the delivery of bad news to ensure appropriateness and consistency of the message being delivered. Clear guidelines must be integrated in the academic education of health care professionals, as also in their continuous in-service education to upgrade professional-patient communication.

### **Recommendation:**

The following implications and recommendations were considered based on the findings of this study: (1) Integrate appropriate communication skills, teaching and spiritual care into undergraduate and postgraduate education in order to use appropriate approach to handle patient's reaction; (2) Since disclosure of information is a process of reciprocal concern to both patients and health care professional, a qualitative research concerning patients' perspectives on prognostic disclosure and emotional responses to such information is recommended, in order to provide appropriate way of conveying information to cancer patient; and (3) Meanwhile, further research about clinicians and patients attitudes towards revealing the truth during a

serious illness and the influence of social and cultural context above them is definitely needed; in different countries and cultures.

### ACKNOWLEDGEMENTS

The authors would like to express my sincere gratitude and thanks to Prof. Dr. K. Elswawi, for her supervision, cooperation and valuable suggestions on the improvement of the manuscript and also, thank all informants who participate in this study.

### REFERENCES

1. Rahman S, Mahmud M, Mohamed, A. Disclosure of cancer diagnosis and prognosis from patients' perspectives at Hospital Universiti Sains Malaysia (HUSM). Proceedings of the Regional Conference on Statistical Sciences (RCSS'10). (2010) 256-263.
2. Öksüzoglu B, Abali H, Bakar M, Yildirim N, Zengin, N. Disclosure of cancer diagnosis to patients and their relatives in Turkey: views of accompanying persons and influential factors in reaching those views. *Tumori*. (2006);92: 62-66.
3. Kazdaglis G, Arnaoutoglou C, Karypidis D, Memekidou G, Spanos G, Papadopoulos O. Disclosing the truth to terminal cancer patients: a discussion of ethical and cultural issues. *Eastern Mediterranean Health Journal*. (2010);16 (4): 442-447.
4. Al-Amri A. Saudi Cancer Patients' Attitudes towards disclosure of cancer information. *Middle East Journal of Cancer*. (2010);1 (4): 175-180.
5. Beyraghi N, Mottaghipour Y, Mehraban A, Eslamian E, Esfahani, F. Disclosure of cancer information in Iran: a perspective of patients, family members, and health professionals. *Iran J Cancer Prev*. (2011);3: 130-134.
6. Perera M, Tennakoon T, Kumarasiri L, Jayasinghe S, Rathnayake R, Rajapaksha, R. Cancer in Sri Lanka: The question of, "To Tell or Not to Tell". *Ceylon Journal of Otolaryngology*. (2013);3 (1): 17-19.
7. Shahidi J, Taghizadeh-Kermani A, Yahyazadeh S.H, Khodabakhshi R, Mortazavi S.H. Truth-telling to Cancer Patients from Relatives' Point of View: A Multi-centre Study in Iran. *Austral - Asian Journal of Cancer*. (2007);6 (4): 213-217.
8. Sarafis P, Tsounis A, Malliarou M, Lahana E. Disclosing the Truth: A Dilemma between Instilling Hope and Respecting Patient Autonomy in Everyday Clinical Practice *Global Journal of Health Science*. (2014);6 (2): 128-137.
9. Innes S, Payne S. Advanced Cancer Patients' Prognostic Information Preferences: A Review. *Palliative Medicine*. (2009);23: 29-39.
10. Costantini M, Morasso G, Montella M, Borgia P, Cecioni R, Beccaro M, Sguazzotti E, Bruzzi P. Diagnosis and prognosis disclosure among cancer patients : results from an Italian mortality follow-back survey. *Annals of Oncology*. (2006);17: 853-859.
11. Jawaid M, Qamar B, Masood Z, Jawaid S. Disclosure of cancer diagnosis: Pakistani patients' perspective. *Middle East Journal of Cancer*. (2010);1 (2): 89-94.
12. Sato R, Beppu H, Iba N, Sawada A. The meaning of life prognosis disclosure for Japanese cancer patients: A qualitative study of patients' narratives. *Chronic Illness*. (2012);8 (3): 225-236.

13. Oksel E, Ertem G, Dönmez Y. Lived experiences of nursing students with mothers/fathers with cancer: phenomenologic approach. *Asian Pacific Journal of Cancer Prevention*. (2010);11: 1009-1014.
14. Matlakala M, Mokoena J. Student nurses' views regarding disclosure of patients' confidential information, *S. Afr Fam Pract*. (2011);53 (5): 481-487.
15. Tsoussis S, Papadogiorgaki M, Markodimitraki E, Delibaltadakis G, Strevinas A, Psyllakis M, Tabakaki K, Drossitis I, Kabourakis A, Papadimitraki E, Kryptos S, Daskalakis K, Fragiadaki G, Zoumadaki E, Apostolakis S. Disclosure of cancer diagnosis: the Greek experience. *JBUON*. (2013); 18 (2);516-526.
16. Woldemariam Y. Perception of nurses on disclosure of children's HIV positive status in Addis Ababa, Ethiopia. Master of Public Health, University of South Africa. (2012);52-55; 64.
17. Sheldon L. Grounded theory: Issues for research in nursing. *Nurs Stand*. (1998);12: 47-50.
18. Strauss A, Corbin J. Basics of qualitative research: techniques and procedures for developing grounded theory. (2<sup>nd</sup> ed.). Thousand Oaks, Ca: Sage. (1998);55-242.
19. Cohen M, Kahn D, Steeves R. How to analyze the data. in: hermeneutic phenomenological research: a practical guide for nurse researchers. Thousand Oaks, Ca: Sage Publications. (2000);71-82.
20. Giacomini M, Cook D. Users' Guide to the Medical Literature: XXIII Qualitative research in healthcare: Are the Results of the Study Valid? *Jama*. (2000);283, 357-362.
21. Nelson J. Struggling to Gain Meaning: Living with the uncertainty of breast cancer. *Advanced Nursing Science*. (1996);18 (3): 59-76.
22. Al-Amoudi S. Cancer diagnosis: Who has the right to know?. *Journal of Women's Health, Issues and Care*. (2013);2 (4): 1-4.
23. Elsiddek A, Eltayeib E, Salahedin M, Elbakhiet T, Ibnouf M. Breaking bad news for patients with gastro-intestinal malignancy: experience at Ibn Sina Teaching Hospital. *Sudan JMS*. (2014); 9 (1): 1-8.
24. Hancock K, Clayton J, Parker S, Walder S, Butow P, Carrick S, Currow D, Ghersi D, Glare P, Hagerty R, Tattersall M. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliative Medicine*. (2007);21: 507-517.
25. Sheu S, Mu P. (2008). The nurses' experiences of truth telling to the terminal cancer patients: a systematic review: 1-8
26. Smith T. J, Dow L.A, Virago E. A, Khatcheressian J, Matsuyama R, Lyckholm L. A pilot trial of decision aids to give truthful prognostic and treatment information to chemotherapy patients with advanced cancer. *The Journal of Supportive Oncology*, .(2013); 9 (2): 79-86.
27. Baile W, Buckman R, Lenzi R, Guber G, Beale E, Kudelka. A. SPIKES—A Six-Step protocol for delivering bad news: application to the patient with cancer. *The Oncologist*. (2000);5: 302-311.
28. Fallowfield L, Jenkins V. Communicating Sad, Bad, and Difficult News in Medicine. *Lancet*. (2004);363, 319, 312.

29. Back A, Arnold R. Discussing Prognosis: "How Much Do You Want to Know?" Talking to Patients Who Are Prepared for Explicit Information. *Journal of Clinical Oncology*. (2006);24 (25): 4209-4213.

30. Neiders I, Sile V, Silis V. Truth-Telling and the asymmetry of the attitude to truth-telling to dying patients in Latvia. *Studia Philosophica Estonica*. (2013);6 (2): 55-78.

How to cite this article: Hashem H, Ismail L. Nursing student's experience on truthful disclosure of information to cancer patients. *Int J Health Sci Res*. 2015; 5(6):366-378.

\*\*\*\*\*

**International Journal of Health Sciences & Research (IJHSR)**

**Publish your work in this journal**

The International Journal of Health Sciences & Research is a multidisciplinary indexed open access double-blind peer-reviewed international journal that publishes original research articles from all areas of health sciences and allied branches. This monthly journal is characterised by rapid publication of reviews, original research and case reports across all the fields of health sciences. The details of journal are available on its official website ([www.ijhsr.org](http://www.ijhsr.org)).

Submit your manuscript by email: [editor.ijhsr@gmail.com](mailto:editor.ijhsr@gmail.com) OR [editor.ijhsr@yahoo.com](mailto:editor.ijhsr@yahoo.com)